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Physicians' Fears Of Malpractice Lawsuits Are Not Assuaged By Tort Reforms

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ABSTRACT **Physicians contend that the threat of malpractice lawsuits forces them to practice defensive medicine, which in turn raises the cost of health care. This argument underlies efforts to change malpractice laws through legislative tort reform. We evaluated physicians' perceptions about malpractice claims in states where more objective indicators of malpractice risk, such as malpractice premiums, varied considerably. We found high levels of malpractice concern among both generalists and specialists in states where objective measures of malpractice risk were low. We also found relatively modest differences in physicians' concerns across states with and without common tort reforms. These results suggest that many policies aimed at controlling malpractice costs may have a limited effect on physicians' malpractice concerns.**

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Although analysts disagree about the scope and cost of defensive medicine,[1] physicians consistently report that they often engage in defensive practices and that they feel intense pressure to do so out of fear of becoming the subject of a malpractice lawsuit.[2]

Fear of being sued may compromise physicians' ability to communicate effectively with patients, particularly in disclosing medical errors.[3] Physicians with high malpractice insurance premiums, which reflect a risky liability environment, have lower career satisfaction and report more adversarial relationships with patients than do physicians with lower premiums.[4] Physicians with high premiums are also more likely to order diagnostic testing and hospitalize low-risk patients in some settings.[5]

Federal health reform has heightened concerns about defensive medicine for two reasons. First, the financial and organizational changes wrought by health reform have introduced new sources of stress for health care providers, sharpening their demands for liability reform in exchange for their support on other health reform measures. Second, because it leads to defensive medicine, liability risk is an obstacle to health reform's ambition of moving physicians toward more cost-effective care.[6]

In this article we report findings concerning perceptions of malpractice risk among a nationally representative sample of physicians. Our objectives were to assess levels of physician concern about malpractice, examine associations between level of concern and physician practice characteristics, and relate these concerns to objective measures of malpractice risk, including state medical malpractice reform laws.

We found that individual physicians' concerns about their own malpractice risk are pervasive, vary across specialties in ways that are likely to reflect underlying malpractice risk, and reflect objective measures of risk across states to a limited degree. Our results suggest that many popular tort reforms are only modestly associated with the level of physicians' malpractice concern and their practice of defensive medicine. The results raise the possibility that physicians' level of concern reflects a common tendency to overestimate the likelihood of "dread risks"—rare but devastating outcomes—not an accurate assessment of actual risk.

Study Data And Methods

DATA Physician data were obtained from the 2008 Center for Studying Health System Change (HSC) Health Tracking Physician Survey, a nationally representative mail survey of U.S. physicians who provide at least twenty hours of direct patient care per week. The survey was sponsored by the Robert Wood Johnson Foundation. The sample of physicians was drawn from the American Medical Association (AMA) Physician Masterfile and included active, nonfederal, office- and hospital-based physicians. Residents and fellows were excluded, along with radiologists, anesthesiologists, and pathologists.

The survey had a response rate of 62 percent ($N = 4,720$). It asked a broad array of questions regarding physicians' demographic and practice characteristics, as well as subjective questions dealing with such issues as career satisfaction and concerns about malpractice.[7]

To assess the association between malpractice concerns and state-level data on malpractice risk and malpractice premiums, we used secondary data from the National Practitioner Data Bank, available on the Kaiser Family Foundation Web site;[8,9] the *Medical Liability Monitor*;[10] market share reports published by the National Association of Insurance Commissioners;[11] and the AMA Physician Masterfile, obtained from the Kaiser Family Foundation Web site.[12] Malpractice premium data for obstetrics and gynecology, general surgery, and internal medicine from the *Medical Liability Monitor* were weighted by market share data from the National Association of Insurance Commissioners. Information on state tort reforms affecting malpractice litigation was obtained from the database of state tort law reforms, developed by Ronen Avraham.[13] Each reform was considered separately.

With cross-sectional data, it is difficult to infer a causal association between specific laws and physicians' malpractice concerns. Some states may have adopted multiple laws that changed the way malpractice claims are addressed, including caps on various types of damages, as a way to respond to existing high levels of overall malpractice risk. To capture the temporal relationship between states' policies and physicians' concerns, we used data on medical malpractice laws in effect in 2007, one year before the 2008 physician survey. (See the Appendix for a description of state policies.)[14]

ASSESSMENT OF CONCERNS The survey included questions from a malpractice concerns scale developed and validated by Kevin Fiscella and colleagues.[15–19] The questions asked respondents to indicate how strongly they agreed with the following statements based on a five-point Likert scale, ranging from "strongly disagree" to "strongly agree": (1) I am concerned that I will be involved in a malpractice case sometime in the next ten years. (2) I feel pressured in my day-to-day practice by the threat of malpractice litigation. (3) I order some tests or consultations simply to avoid the appearance of malpractice. (4) Sometimes I ask for consultant opinions primarily to reduce my risk of getting sued. (5) Relying on clinical judgment rather than on technology to make a diagnosis is becoming risky because of the threat of malpractice suits.

We computed the percentage of statements with which each respondent agreed or strongly agreed, across the five statements. The resulting composite score is reported on a scale of 0 to 100.

We compared regression-adjusted means of the composite score across respondents with different individual and practice characteristics, as well as across physicians in different groups of states as defined by values on various measures of malpractice risk, including enacted tort reforms. We also used regression-adjusted means to compare composite scores between specialty groups and to compare physicians across tertiles (thirds) of statewide malpractice risk.

We controlled for differences in the characteristics of physicians, practices, and patient panels. Those characteristics included physician's sex, years in practice, and practice type; number of physicians in practice; percentage of practice revenue from Medicare and from Medicaid; percentage of patients who suffer from chronic diseases; and percentage of patients who are members of racial and ethnic minority groups. Generally, adjusted means differed little from unadjusted ones.

We further report the results of two distinct subscales representing malpractice concerns (statements 1, 2, and 5 on the malpractice concerns scale) and defensive medicine (statements 3 and 4 on the scale). All analyses used survey weights to adjust for probability of selection and differential survey nonresponse.

LIMITATIONS Our study has limitations. Our measure of malpractice insurance premiums is at the state level and does not reflect the premium burden experienced by individual respondents. Similarly, we do not have any information on individual physicians' awareness of individual tort reforms intended to limit malpractice claims.

We have no measure of claims that are closed but did not result in payment, which nonetheless might cause distress and professional and financial loss to physicians. Performing a statistical adjustment used in previous studies to approximate the number of closed claims did not reveal new significant associations with tort reforms.[2]

Our sample population excludes radiologists